Wyoming Department of Health
Public Health Laboratory
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REQUISITION FOR INFLUENZA TESTING

INSTRUCTIONS FOR INFLUENZA TESTING
➢ Specimens should be collected within 3 days of symptom onset
➢ Specimens should be collected & shipped according to attached protocol
➢ Specimens must arrive at the lab within 48 hours of collection
➢ Maintain Specimen at **2-4 °C** and ship on COLD PAK to the WPHL with the completed form

(Please print clearly with black ballpoint pen.)

Patient Name (Last)　　　(First)　　　(MI)	Epidemiology Requested Case: ☐ **Yes** *(outbreak / unusual case)*
Patient Address　　　　　　**Home Phone** 　　　　　　　　　　**(　　)**	☐ **No** *(ILINet sentinel provider)*

Hispanic: ☐ Yes ☐ No ☐ Unknown Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American 　　☐Native Hawaiian or Pacific Islander ☐White ☐Unknown ☐Other	DOB 　/　/	Gender ☐ Male
	Age	☐ Female

Submitting Laboratory Name and Address (return address)	Phone Number (　) **Fax Number** (　)

Attending Physician Name _____

COMPLETE ENTIRE SECTION BELOW TO ENSURE CORRECT TESTING INFORMATION

Date of onset of illness: ____/____/____	**SAMPLE TYPE**　　　**DATE COLLECTED**
	☐ **Nasopharyngeal swab**　____/____/____
Rapid Flu Test Results:	☐ **Nasal swab**　　　　____/____/____
☐ **Negative**　　☐ **No rapid test performed**	☐ **Nasal wash/aspirate**　____/____/____
☐ **A positive**　　☐ **B positive**	
☐ **A & B positive (Not Differentiated)**	☐ **Other**_____　____/____/____

Was patient hospitalized? ☐ Yes ☐ No	**Patient Symptoms:**
	☐ **Sore throat**　　☐ **Fever** *(≥ 100.0 °F)*
If yes: Hospital _____	
	☐ **Headache**　　☐ **Nasal congestion**
Date Admitted ____/____/____	☐ **Dry cough**　　☐ **Shortness of breath**
Flu Vaccination ☐ Yes ☐ No	
	☐ **Body Aches**　　☐ **Diarrhea**
If yes, date received: ____/____/____	
	☐ **Vomiting**　　☐ **Other** _____
Nasal Vaccination ☐ Yes ☐ No	

Patient Name: _____   DOB: /   /

Highest fever at home _____° F or ☐ N/A **Date taken: _____/_____/_____** **Highest fever during _healthcare_ visit _____° F**	**Travel outside USA? ☐ Yes ☐ No** **If yes, list country: _____** **Date of Travel _____/_____/_____**

Did the patient receive antiviral medication?

☐ **Yes**   ☐ **No**   ☐ **Unknown**

If yes, complete the table below

Drug	Start Date	Number of days	Dosage
Tamiflu *(Oseltamivir)*			
Relenza *(Zanamivir)*			
Rimantadine			
Amantadine			
Other_____			

Does the patient have any of the following?

☐ **Asthma**

☐ **Other chronic lung disease**

☐ **Cancer**

☐ **Neurological disease**

☐ **Kidney disease**

☐ **Chronic heart /Circulatory disease**

☐ **Metabolic disease** *(including diabetes mellitus)*

☐ **Obesity** *(≥ 30.0 BMI)*

☐ **Other Chronic Disease _____**

Does the patient work in a healthcare facility/setting?
 	
☐ **Yes**   ☐ **No**   ☐ **Unknown**
 	
If yes: Facility _____
           Address _____
           _____
	Pregnant?
	
	☐ **Yes** ☐ **No** ☐ **Unknown** ☐ **Not Applicable**
	
	If yes, how many weeks _____
	
	Estimated due date: _____/_____/_____

Does the patient attend school? ☐ **Yes** ☐ **No** ☐ **Unknown** **If yes: School _____**	**Does the patient attend daycare?** ☐ **Yes** ☐ **No** ☐ **Unknown** **If yes: Daycare _____**
Patient's weight _____ kg or lbs **Patient's height _____ cm or ft/in** **Part of a suspected cluster or outbreak?** ☐ **Yes** ☐ **No** ☐ **Unknown** **If yes, list other possible cases** _____ _____ _____	**Level** *(s)* **of medical care** *(check all that apply)* ☐ **Clinic visit** *(outpatient)* ☐ **Emergency Department / ER visit** ☐ **In-patient admission** *(hospitalized patient)* ☐ **Intensive Care Unit** *(ICU)* ☐ **Long-term Care Facility** *(LTCF / Nursing home)* ☐ **Other _____**

Did the patient die? ☐ **Yes**   ☐ **No**   ☐ **Unknown**   **If yes, date of death: _____/_____/_____**

If yes, location: ☐ Home ☐ ER   ☐ Hospital ☐ ICU   ☐ LTCF   ☐ Other *(specify)*:_____

(Complete only if the patient died)

Requested autopsy? ☐ Yes ☐ No ☐ Unknown   If yes, autopsy location _____

Invasive bacterial infection? ☐ Yes ☐ No ☐   Unknown   If yes, list organism _____

Sterile site source: ☐ Blood   ☐ Tissue   ☐ CSF   ☐ Pleural fluid   ☐ Other *(specify)*:_____